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Identifying a common core of integrated healthcare program requirements

Implications for workforce development

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Disclaimer

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Goals

- **Identify and define an *initial set* of core elements of IHC based on three broad frameworks.**
- **Compare and contrast how core elements are expressed in IHC models of several funding and accrediting bodies.**
- **Discuss workforce implications for two core elements: Team – Based Care and Self-Management**

Tell us about you

- What's your role on the project?
  - PD, PC provider, BH provider, Peer, admin
- What primary care model are you using?
  - Partner with FQHC
  - Stand Alone
  - Partner with non – FQHC
  - Serves as PCP for another agency
- Is this your original primary care model or a modified model?

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Lessons Learned from Existing Examinations of PCMH Core Elements

- Standards in PCMH recognition tools vary widely in emphasis[1,2]
- Measures often address core elements that are easier to assess[3]
- Lack of research indicating which standards are most closely related to improved performance, patient outcomes, and cost[4]
- Organization of recognition tools vary so comparison process takes time and effort[1,3]

[1]Burton, Devers, Berenson (2010). [2]Stange, Nutting, Miller et al. (2010). [3]Stange, Miller, Nutting (2010), [4]Alexander & Druss (2012)

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Our Initial Set of Core Elements of BHH

- **Based on three frameworks[1?]**
  - *CMS Health Home Service Requirements*
  - *Chronic Care Model (CCM), essential elements for high-quality chronic disease care*
  - *Four Principles of Effective Care (AIMS Center, University of Washington, 2011)*
- **Used an inductive, bottom-up, review process [2]**

[1]Alexander & Druss (May, 2012); [2]Crane & Panzano, 2014

Elaborated Set of Core Elements by Review of Program Standards

Documents reviewed for preliminary analyses [5]

- **CARF Health Home**
- **CARF Integrated Behavioral Health and Primary Care**
- **Ohio Health Home Certification Criteria**
- **The Joint Commission, Behavioral Health Home Certification**
- **The Joint Commission, Primary Care Medical Home**
- **SAMHSA Primary Behavioral Health Integration Projects**
- **HRSA Federally Qualified Health Centers**
- **NCQA PCMH**

Under review: CPC; CCBHC; PIPBHC

Elaborated Set of 13 Core Elements

- **Patient and Family Centered Care**
- **Culturally Appropriate Care**
- **Comprehensive Care Plan**
- **Use of continuing care strategies to include**
  - *Care Management*
  - *Care Coordination*
  - *Transitional Care*
- **Self-Management (SM) and SM Support**
- **Team-based care**
- **Full Array of Services (e.g., PC, MH, SA, Prevention, Health Promotion),**
- **Quality Improvement Processes**
- **Evidence Based Practice/Clinical Guidelines**
- **Outcomes measurement**
- **Health Info Technology & EHR Meaningful Use**
- **Enhanced Access to care**
- Miscellaneous Org-Level Requirements

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Conducted Detailed Review Example: Person Centered Care

CARF IBHPC	CARF HH	OHH	TJC HH Cert	TJC PCMH	PBHCI Program	FQHC - HRSA	NCQA
10b &c, 11, 13b&c, 15d	2e, 7c4, 7c5, 7e, 12b, 13, 15a9, 16b, 18c, 18d, 18e, 18f,	C1a, C1b, C1c, C1e, C5e, C5g, C5h, C5i, C5j, I	CTS.02.02.01-6, CTS.03.01.01-(12,13), CTS.03.01.03-(17,20,22), CTS.04.01.01-7, CTS.04.01.03-27, CTS.04.02.25-(2,4), CTS.06.01.05-(1,4), CTS.06.01.07-(1,2) RI.01.02.01-(31,32,33), RI.01.04.01-6, RI.01.04.03-(1,2,3,4,5,6) RI.01.05.01-(4,5,8,10,11)	RI.01.02.01: EP31, EP32 RI.01.04.03: EP1, EP2, EP3 RI.01.04.03: EP1, EP2, EP3, EP4, EP5, EP6 RC.02.01.01: EP28	1. I. Purpose, 1, pg. 6: / 2. I. Purpose pg. 7: / 3. Expectations, pg 8: / 4. Expectations, pg. 8: / 5. 2.1 Required Services / 6. 2.1 Required Services: Preventive and Health Promotion Services / 7. Appendix M: Suggest Year 1 (of 4) implementation goals	Subpart C: §51c.303 Project elements, (j), (k) §51c.304 Governing board, (b), (b1) Site Visit Guide, Program Requirement #18: Board Composition	Elements 1C1-1C4, 1D2, 1E2, 1E3, 3C2, 3C3, 3C5, 3D3, 6B1

Created 30,000 Foot View

Core Elements	CARF IBHPC	CARF –HH	OHH	TJC HH Cert	TJCP CMH	PBHCI Pgm	FQHC App	NCQA
Patient and Family Centered Care	✓	✓	✓	✓	✓	✓	✓	✓
Culturally Appropriate Care		✓	✓	✓	✓			✓
Comprehensive Care Plan	✓	✓	✓	✓	✓	✓	✓	✓
Continuing Care Strategies (Care Mgmt., Coordination, Transitional Care)	✓	✓	✓	✓	✓	✓	✓	✓
Self-Management (SM) & SM Support	✓	✓	✓	✓	✓	✓	✓	✓
Team–based Care	✓	✓	✓	✓	✓	✓	✓	✓
Full Array of Services (e.g., PH, MH, Health Promotion, LTC)		✓		✓	✓	✓	✓	✓
Quality Improvement Processes	✓	✓	✓	✓	✓	✓	✓	✓
Evidence Based Practice			✓	✓	✓	✓	✓	✓
Outcomes measurement		✓	✓	✓	✓	✓	✓	✓
Health Info Technology/ Meaningful Use		✓	✓	✓	✓	✓	✓	✓
Enhanced Access to care	✓	✓	✓	✓	✓	✓	✓	✓

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Preliminary Observations

- **A ✓≠✓ : 30,000 foot view is somewhat misleading**
  - *Models operationalize elements in different ways*
  - *Different methods used to assess presence of elements (e.g., 'level' of measurement varies from policy – focus vs. focus on patient experience)*[1]
- **The documents reviewed include implied expectations that might get overlooked**
  - **It's important to make implied expectations explicit**
  - *PBHCI and the Chronic Care Model (e.g., PACIC domains)*
- **All core elements have workforce implications**

[1]Crane & Panzano, 2014

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Job Descriptions?

Recruiting?

Selection?

Workforce Implications of Two Elements: Team-based Care and Self-Management

Orientation?

Training?

Performance Assessment?

Retention?

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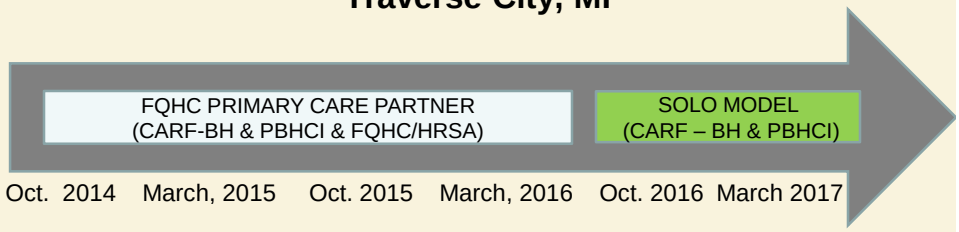

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Team-Based Health Care

Definition

At least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by patient—to accomplish shared goals and achieve coordinated, high quality care.[1]

Inter-disciplinary and inter-professional (e.g., BH professional, PCP, SW, nutritionist, peer support specialist).[1]

Clear roles, mutual trust, effective communication, measurable processes and outcomes.[2]

[1]Adapted from ACA definitions of team in Sections 2703 and 3502

[2]IOM White Paper: Mitchell, Wynia, Golden et al (October 2012), Core Principles and Values of Effective Team-based Health Care.

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Team[1]-based Care: Structure

Sub-Feature	CARF HH	CARF IBHPC	OH H	TJC HH	TJC PCMH	PBHCI	FQHC [1] App	NCQA
The team has a designated caseload				✓	✓			
Members from complementary disciplines	✓	✓			✓			
Required disciplines or positions are specified (e.g., nurse care manager, embedded PCP, care coordinator)	✓	✓	✓					
A leader for the team is designated			✓	✓				✓
Job descriptions are developed for all clinical and non-clinical team members								✓
Team members are cross - trained	✓	✓		✓		✓		
The team psychiatrist or psychologist is available during all hours of operation	✓[2]	✓[2]						
Required services	See Full Array of Services							

[1] Term "team" does not appear in FQHC regulations;
[2] Can be provided via consultation

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Unique Requirements: Team Structure

- **Required disciplines and roles (e.g., PCP, nurse care manager, care coordinator)**
- **Designated team leader**
- **Designated caseload**
- **Job descriptions for team members**
- **Cross training**

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Team-based Care: Process

Sub-Feature	CARF HH	CARF IBHPC	OHH	TJC HH Cert	TJC PCMH	PBHCI Pgm	FQHC	NCQA
Service delivered in integrated way	✓	✓	✓[1]					
Patient-centered approaches used	See Person-Centered Care							
Warm handoffs are provided to clients	✓							
All team members review care plans	✓			✓				
Coverage plans for absent disciplines or team members are specified	✓	✓						
Team members follow written procedures for collaborating with external providers	✓	✓	✓	✓				
A structured approach is used to foster communication among team members (e.g. written procedures, team meetings, HIT	✓	✓			✓			✓
Care Management., Care Coordination, Transitional Care	SEE Continuing Care Strategies							

[1] Integrated delivery may involve different approaches (face to face, video conferencing, telephone)

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Unique Requirements: Team Process

- Structured communication (e.g., team meetings, written procedures, HIT)
- Procedures for collaboration with external providers
- Warm handoffs
- All team members review care plans
- Coverage plans when discipline absent

Workforce Questions

What workforce strategies (e.g., selection, job descriptions, orientation, training, performance feedback) has your organization you used to:

1. **Define what you mean by team – based care?**
2. **Build and sustain an effective team for your IHC program?**
3. **Insure team members have a good/clear understanding of their roles?**
4. **Facilitate effective communication among team members and with internal (e.g., psychiatrist) and external partners (e.g., providers you refer to) of the team?**
5. **Support efforts by project leaders to facilitate team commitment, cohesiveness, and communication?**

Self Management (SM) & SM Support

- **Self-Management: A set of tasks that individuals must undertake to live well with one or more chronic conditions. It is <u>what the person with a chronic disease does</u> to manage their own illness, not what the health service provider does.[6]**
- **Self-Management Support: <u>What others do</u> to assist individuals with chronic illness develop and strengthen their self-management skills.[6]**

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Unique Requirements

Self Management	Self Management Support
Assign responsibility to clients to participate in SM activities	Specify content to be addressed in SM education and training programs
Assign responsibility to client for self-monitoring progress toward goals	Incorporate clients' self management goals into care plan
	Provide SM programming to family members and significant others
	Connect clients (significant others) with peer support for SM
	Provide resources to support SM planning
	Specify staff responsibilities for supporting and monitoring client implementation of SM Plan

Workforce Questions

- **What workforce strategies (e.g., orientation, training, performance feedback) has your organization used to:**

1. **Increase staff's understanding of how your client base conceptualizes self-management ?**
2. **Support the accurate and honest assessment of self-management activities and their impacts/outcomes?**
3. **Clarify how project leadership defines and assesses client self-management activities distinctly from staff self- management support activities?**

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Questions?

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References

[1] Burton R, Devers K, Berenson R: Patient-centered medical home recognition tools: a comparison of ten surveys' content and operational details. The Urban Institute, Health Policy Center, 2010.

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[3] Stange K, Nutting P, Miller W, Jaén C, Crabtree B, Flocke S, Gill J: Defining and measuring the patient-centered medical home. J Gen Intern Med 25: 601-612, 2010.

[4] Alexander L, Druss B: Behavioral health homes for people with mental health & substance use conditions: the core clinical features. SAMHSA-HRSA Center for Integrated Health Solutions, 2012.

[5]Recognition Tools

Commission on Accreditation of Rehabilitation Facilities Standards Manual, ***Health Home supplement to the 2013 Behavioral Health Standards Manual (released July 1, 2013)***

Commission on Accreditation of Rehabilitation Facilities Standards Manual, ***Integrated Behavioral Health and Primary Care supplement to the 2013 Behavioral Health Standards Manual (released July 1, 2013)***

Ohio Health Home Service Standards for Persons with SPMI, ***Ohio Administrative Code 5122-29-33 (effective July 1, 2014)***

Joint Commission Behavioral Health Home Certification Standards, ***for organizations accredited under the Behavioral Health Care Accreditation Program (effective January 1, 2014)***

Joint Commission Primary Care Medical Home Certification ***for organizations accredited under the Ambulatory Care Accreditation Program (version 2011)***

SAMHSA PBHCI RFA: (PPHF-2012), Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243, Applications due 6/8/2012.

Federally Qualified Health Centers:

- *Electronic code of Federal Regulations (e-CFR Data current as of July 8, 2014), Title 42: Public Health, Part 51c – Grants for community health services.*
- *Health Center Program Site Visit Guide for HRSA Health Center Program Grantees and Look-A-likes; January 2014/Fiscal Year 2014*

The National Committee for Quality Assurance Patient-Centered Medical Home 2011 Standards and Guidelines ***(released Jan. 31, 2011)***

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[8] Health, B., Wise, Romero, P., and Reynolds, K.A. A review and proposed standard framework for levels of integrated healthcare, Washington, DC, SAMHSA-HRSA Center for Integrated Health Solutions, March, 2013.

[9] Boon, H., Verhoef, M, O'Hara, D. and Findlay, B. (2004). From parallel practice to integrative health care: a conceptual framework, BMC Health Services Research, 4:15, pages 1-5; open access at http://www.biomedcentral.com/1472-6963/4/15

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